
The Promise of Evidence-Based Practices in Child and Adolescent Mental Health

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THE PUSH for evidence-based practices has dominated the mental health and health care arenas for more than a decade. Conversations among professionals who provide mental health services for youth have included both support and opposition to this position. On the one hand, there is a plethora of discourse indicating widespread support for the need to provide the best available services for youth in need, delivered through the provision of evidence-based practices. On the other hand, there are also opponents to this viewpoint, primarily arguing that evidence-based practices developed in research settings may not fit the context of community providers. A gap already existed between research and practice, and the push for evidence-based practices has further widened the rift between divisions in the mental health field. These divisions include type of provider (e.g., psychologist, social worker) and theoretical orientation (e.g., cognitive-behavioral, psychodynamic). These divisions, coupled with a

lack of infrastructure providing guidance on best practices, create a thorny challenge for the field. For example, pharmacotherapy (medications) receives support from the pharmaceutical industry—an enterprise that provides advertisements, sales representatives, and free samples. No such comparable infrastructure exists for stakeholders examining and finding evidence in support of psychological treatments: Where do stakeholders turn when they want to identify and promote best practices? For decades, the findings of the beneficial effects of psychological treatments for youth were published in scholarly journals read by other researchers, often of like mind, but did not reach those stakeholders who could implement these treatments in community settings.

The evidence-based practice movement in mental health can be attributed to several forces, including the emphasis on evidence-based medicine in health care, an American Psychological Association (APA) task force formed to identify

evidence-based practices, and even insurance companies that, with financial interest, sought to identify the effective and efficient ways to provide coverage for their insured with mental health needs. These efforts gave new and needed airtime to highlight the benefits of psychological treatments that work. Mental health researchers, concurrently, took a more visible stand when espousing the benefits of psychological treatments, the relative merits of psychological as compared with pharmacological treatments and, based on the data, the relative merits of some psychological treatments as compared with others. Further, they began to consider how to disseminate the message of the promise of evidence-based practices to a wider audience.

Gathering the data of which treatments work, sharing the information, and taking a more pronounced stand was a first step. But like-minded mental health professionals speaking to each other were only modestly successful in bringing evidence-based practices to those in need. The emergence of dissemination and implementation (DI), as a focus and as a topic of scientific study, takes the next step, and allows us to achieve the promise of evidence-based practices.

A number of evidence-based mental health treatments for youth have been developed (see Kendall, 2012) and the prior work documents that laudable progress has been made. Unfortunately, the promise of these treatments will remain largely unrealized if the majority of youth in the community cannot access these services (President's New Freedom Commission on Mental Health, 2003). Estimates suggest that it can take up to 17 years for evidence-based treatments to make their way from research to practice (Balas & Boren, 2000). This lag is unacceptable. One of the biggest challenges facing the mental health field is the dissemination and implementation of evidence-based practices from the world of research to the community settings where the services are provided (McHugh & Barlow, 2010). Fortunately, a growing interest in implementation research, the "scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice...to improve the quality and effectiveness of health services" (Eccles & Mittman,

2006), sparks a new energy to realize the promise of evidence-based practices.

The field of implementation science is still in its infancy, and one of the initial tasks is to achieve some terminology clarity (McKibbin et al., 2010). Given this need, we define a few key terms that are used frequently within this book. Evidence-based practices (EBPs) refer to the provision of psychosocial treatments supported by the best scientific evidence while also taking into account clinical experience and client preference (American Psychological Association, 2005). Empirically supported treatments (ESTs) refer to specific psychological interventions that have been evaluated scientifically with real patients and independent evaluators (e.g., a randomized controlled trial [RCT]) and then replicated by others (Chambless & Hollon, 1998). *Dissemination* refers to the purposeful distribution of relevant information and materials to mental health providers and *implementation* refers to the adoption and integration of EBPs (hereafter including ESTs) into practice (Lomas, 1993). Dissemination and implementation are best when they occur in tandem: Both are needed to influence systemic change (Proctor et al., 2009).

The promise of the DI of EBP can be realized for a number of stakeholders, including policy makers, researchers, clinicians, administrators, and consumers. Policy makers can benefit by enacting system-level changes that transform community mental health care. For example, in the city of Philadelphia, exemplar efforts are underway to implement EBPs on a large scale (see Beidas et al., 2013). Researchers and treatment developers benefit when their work is disseminated and implemented in community settings rather than languishing on shelves. Clinicians benefit by improving their practice, and administrators benefit by having agencies that provide the most effective services. Finally, consumers benefit as they receive the treatments that are most likely to provide the greatest rate of improvement in symptoms and return to adaptive functioning. All of these stakeholders comprise the intended audience for this book.

We set out to provide cutting-edge knowledge in DI as it relates to EBPs in child and adolescent mental health. We arranged this book in four

sections: (a) background information relevant to DI, (b) system-level approaches to implementing EBPs for youth in community mental health settings, (c) approaches to implementing EBPs for youth in schools, and (d) approaches to implementing EBPs for youth using technology.

In Part Two, general issues and themes relevant to DI of EBPs for youth are discussed. The models, theories, and frameworks that guide DI are considered first (Chambers, chapter 2). Measurement issues (Proctor, Powell, & Feeley, chapter 3) and capturing fidelity in community settings (Schoenwald, Chapman, & Garland, chapter 4) are discussed next. Organizational (e.g., culture and climate; Williams & Glisson, chapter 5) and leadership considerations (Aarons, Farahnak, & Ehrhart, chapter 6) are addressed, followed by considerations of how best to close the research to training gap in DI science (Frazier, Bearman, Garland, & Atkins, chapter 7).

We next highlight exemplars of implementing EBPs for youth in various settings (i.e., community mental health, schools) and innovative methodologies (i.e., technology). In Part Three, exemplars of implementation from system-level approaches are provided, including practice-research partnerships (Chamberlain & Saldana, chapter 8), implementation of EBPs for youth using state-wide systems as a laboratory (Nadeem and colleagues, chapter 9), implementation of EBPs for youth in England (Shafran, Fonagy, Pugh, & Myles, chapter 10), global DI in low- and middle-income countries (Murray, Dorsey, & Lewandowski, chapter 11), and Building and Sustaining an Evidence-Based Service System in Hawaii (Nakamura, Slavin, Shimabukuro, & Keir, chapter 12).

In Part Four, exemplars of implementation of EBPs for anxiety for youth in schools (Wei and colleagues, chapter 13), disruptive disorders (Boxmeyer and colleagues, chapter 14), autism (Locke, Kratz, Reisinger, & Mandell, chapter 15), depression (Benjamin and colleagues, chapter 16), and trauma (Kataoka and colleagues, chapter 17) are highlighted.

In Part Five, the use of technology takes the forefront, with exemplars of implementation of EBPs for youth using technology for anxiety (Khanna, Kerns, & Carper, chapter 18) and

early child behavior problems (Elkins & Comer, chapter 19).

The field of implementation science is alive and flourishing. With a special eye toward the DI of EBPs for youth, we hope that this book will guide the next needed steps toward progress and will be consumed by a wide range of stakeholders.

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